

## INSURANCE VERIFICATION

To determine what kind of insurance benefits you have for behavioral health, please call the number on your card and use this form to receive the answers you need. Please be certain to record the date you called and name of the Customer Service person who assisted you. If you cannot quite catch their name, ask them to spell it.

Date called: \_\_\_\_\_ Name of Representative: \_\_\_\_\_

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone number: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_

Insurance ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

Do you have mental health coverage?      YES      NO (if no, stop here)

Am I an in-network provider on this plan?      YES      NO (if no, ask about out of network benefits)

Date coverage began: \_\_\_\_\_ Calendar year policy? YES NO

Do you have a deductible?      YES      NO

How much is your deductible? \_\_\_\_\_ Has it been met? YES NO

How much is remaining on your deductible? \_\_\_\_\_

What is your copay amount OR percentage of your co-insurance? \_\_\_\_\_

Is there a maximum number of visits allowed per year? YES (#of visits: \_\_\_\_\_) NO

Is there a dollar amount maximum allowed? YES (amount: \_\_\_\_\_) NO

Are there any limitations on diagnoses or type of counseling?      YES      NO

If there are limitations, what are they: \_\_\_\_\_

Is family counseling allowed?      YES      NO

Is preauthorization required?      YES      NO

If preauthorization is required, will they go ahead and set it up for you?

**Starting & Ending Dates for Authorization:** \_\_\_\_\_

**Number of Visits Authorized:** \_\_\_\_\_

**Authorization Code:** \_\_\_\_\_

**NOTES:** \_\_\_\_\_

\_\_\_\_\_

**Form completed by:** \_\_\_\_\_